



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: USMD HOSPITAL AT ARLINGTON 801 WEST INTERSTATE 20 ARLINGTON TEXAS 76017	MFDR Tracking #: M4-09-2904-01
Respondent Name and Box #: EMPLOYERS MUTUAL CASUALTY CO REP BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...the claim was submitted with the correct procedure codes...The patient had a bilateral lumbar hardware block of the L4, L6 and S1 pedicle screws and fluoroscopic localization and guidance. The procedure code we are billing with is 62311 – lumbar, sacral (caudal) and according to Ingenix current procedural coding expert 2008 this is the correct procedure code. There is exclusion if procedure 77003 was not performed and that procedure was performed. Procedure code 90772 is the procedure code that was suggested that we re file with and according to Ingenix 2008 current procedural coding expert this code is inappropriate..."

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought \$1,934.90

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...Carrier is maintaining its dispute in this matter as the provider supplied the incorrect procedure code. The code 62311 necessary requires injection into the subarachnoid or epidural spaces; that is not the procedure performed. The carrier informed the provider that the bill should be re-coded to show procedure code 90772, but the provider has not submitted anything new other than the request for medical review..."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/26/2008	Hospital Outpatient Services CPT Code 62311 x 6	\$1,542.51 (APC) + \$0.00 (Fee Schedule) + \$0.00 (Outlier Amount) = \$1,542.51 (OPPS) x 200% = \$3,085.02 - \$0.00 (Total paid by Respondent) = \$3,085.02.	\$1,934.90	\$1,934.90
Total Due:				\$1,934.90

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:

Explanation of benefits with the listed date of audit 09/22/08

- 16 — Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- 270 — No allowance has been recommended for this procedure/service/supply. Please see special ‘note’ below.
- 912 — Charges have been review and reduced or denied by our nurse review unit.
- ** — Epidural injections not performed need appropriate block code.

Explanation of benefits with the listed date of 11/03/2008

- 16 — Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was preprocessed [sic] properly.
- 270 — No allowance has been recommended for this procedure/service/supply. Please see special ‘note’ below.
- 710 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 912 — Charges have been review and reduced or denied by our nurse review unit.
- ** — Per our Nurse Review Unit R0360/62311 is not an appropriate code, epidural injections not performed, recommending 90772 X 6 (hardware block). If you wish to continue to dispute the reduction of billed charges in accordance with the DWC Rule 133.305, please contact the Texas Department of Insurance, Division of Workers’ Compensation, Medical Review Division.

2. The submitted preauthorization letter dated 07/21/08 indicates authorization of Hardware Block L4/L5, L5/S1 (1 procedure); to start on 07/21/08 and end on 08/29/08. A review of the medical records identify that treatment rendered was Bilateral Lumbar Hardware Block, L4, L5 and S1 Pedicle Screws with Fluoroscopic Localization and Guidance. As the services rendered did receive authorization, reimbursement is recommended in accordance with Rule 134.403(f).
3. A review of the UB-04 forms identify that the Requestor billed CPT code 62311. By descriptor, the CPT code of 62311 is an injection to the lumbar sacral (caudal). The Respondent asserts that CPT code 90772 is the appropriate procedure code that should have been billed. By descriptor, the CPT code of 90772 is a therapeutic, prophylactic or diagnostic, subcutaneous or intramuscular non-antineoplastic hormonal therapy injection.
4. In accordance with Rule 133.240 (c), “The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code’s value.” The insurance carrier’s letter dated 12/02/08 states, “...procedure code 90772 best described the service that was provided...A re-evaluation was performed and mailed to provider during the first full week in November of 2008, with the recommendation that billed procedure codes 62311 be re-coded and re-submitted as procedure code 90772...”
5. Rule 134.403 (e) states in pertinent part, “Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;...”
6. Pursuant to Rule 134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this

section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

7. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services
8. In reference to disputed code 62311, the payment status indicator is T. T is defined as “Paid under OPPS; separate APC payment. Outpatient significant procedures subject to multiple procedure discounting. The highest payment Status T APC is paid at 100%; all others are paid at 50%.” It is for this reason that payment is recommended for the disputed service.
9. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
 - (1) No contract exists;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was *NOT* requested by the requestor.
10. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Fee Sch	Outlier Payment	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Fee Schedule + Outlier Payment X 200%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
\$1,542.51	\$0.00	\$0.00	\$0.00	\$3,085.02	\$0.00	\$1,934.90.

11. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor, USMD Hospital at Arlington, is due additional payment. As a result, the amount ordered is \$1,934.90.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305
28 TAC Rule §133.240

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,934.90 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

September 28, 2009

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.